Learning to Lean into the Storm

Strategies and Interventions for High-Risk Youth

By Eboni Webb, PsyD, HSP

At-Risk Behavior Through the Lens of Trauma

Week 1

Today's Objectives

1. Define trauma and attachment
2. Understand the impact of trauma on the developing mind
3. Identify common survival resources
4. Learn how adaptive coping is strengthened by autonomic biological responses.

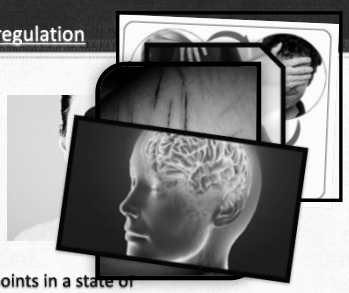
1 Trauma and the Developing Brain

Trauma Theory

Sources of Traumatic Vulnerabilities

- In utero assaults
- Delivery difficulties
- Health of both parents during conception
- Mental Illness
- Abandonment via adoption
- Divorce
- Prolonged separation from parents and/or siblings
- Frequent moves
- School transitions
- Bullying (Cyber, physical, etc.)
- Learning difficulties
- Identity disturbances
- Racial issues
- Inside threats
- Sexual assaults
- Accidents (falls, vehicle, etc)

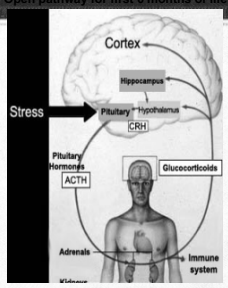
Types of Dysregulation



IQ drops 17 points in a state of emotional dysregulation

Hypothalamic Pituitary Adrenal Axis

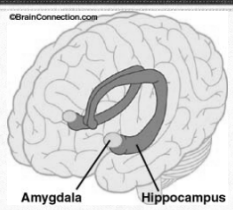
Open pathway for first 6 months of life



Excessive Cortisol Effects

- Neurotoxic to the Hypothalamus
- Neuron Death
- Clogging of the corpus callosum connecting the left and right hemispheres
- Suppression of the immune system

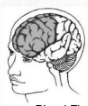
Amygdala: Fight, Flight, and Freeze



Features

- Reactionary
- Triggers Sensory System (Smell and Touch are the most direct pathways)
- Controls autonomic responses

What Happens During a Stress Response?

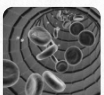


Blood Flow Decreases

- Frontal Lobe
- Nondominant Hemisphere

Sensory System Activates

- Hypervigilance
- Heightened 5 senses



Blood Flow Increases

- Heart
- Extremities
- Decreases to Gut
- Digestive Issues

Acute Response to Threat Study

"In the brains of people who have been abused, the genes responsible for clearing cortisol were 40% less active"
(Morse &Wiley, 2012)

Hyperaroused Continuum	Rest (Male Child)	Vigilance (crying)	Resistance (Freeze)	Defiance (posturing)	Aggression (hitting, spitting,etc)
Hypoaroused Continuum	**Rest (Female Child)**	**Avoidance (Crying)**	**Compliance (Freeze)**	**Dissociation (Numbing)**	**Fainting (checking out, mini-psychosis)**
Primary Brain Areas	Neocortex	Subcortex	Limbic	Midbrain	Brainstem
Cognition	Abstract	Concrete	Emotional	Reactive	Reflexive
Mental State	Calm	Arousal	Alarm	Fear	Terror

Dysregulation: Learned Behavior

1 Invalidating Environment — 2 Cortisol Release — 3 Distress Cues Dysregulation

Cortisol=Automatic (Uncomfortable) reaction

Affect Regulation

Hyperarousal-Fight, Flight, Freeze,

Window of Tolerance

Hypoarousal-Dissociation, Numbing, Depression

Sensorimotor Psychotherapy Institute®
Sensorimotor Psychotherapy founder, "Pat Ogden

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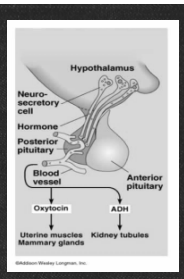
Stress Management

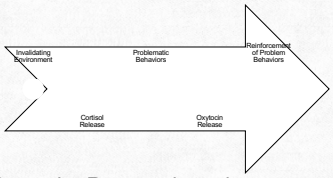
Our Body's Natural Defense

Oxytocin

Hormonal Counter to Cortisol
Architect of Regulation



How Problematic Self-Regulation is Learned

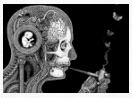


Oxytocin=Responsive release (calming)
Problem Behaviors=reinforced as a

Treatment Targets to Increase Oxytocin Without Problem Behaviors

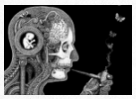
Activities

- Hugs
- Sing in a choir
- Give a back rub/foot rub
- Hold a baby
- Stroke a dog or cat
- Perform a generous act
- Pray
- Make positive eye contact
- Breath work
- Listen without judgment
- Positive touch
- Proximity
- Laugh/Dance



Common Types of Invalidation

- Abuse and neglect
- Open rejection of thoughts, feelings, and behaviors
- Making "normal" responses "abnormal"
- Failing to communicate how experience "makes sense"
- Expecting behaviors that one cannot perform (e.g., due to developmental level, emotionality, or behavioral deficits



3 Equity vs. Equality

Therapy focused on authoritative and connected strategies

Child-Adolescent-Adult Styles

Parent Attachment Style & Adoption

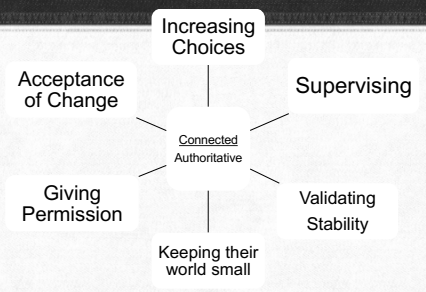
Parent Attachment Style	Childhood Attachment Type	American Population %	% of Low-Risk Adoption	% of Troubled Adoptions (e.g. trauma, abuse, illness)
Autonomous/Free	Secure	15%		
Dismissing	Avoidant		20%	42%
Entangled	Ambivalent		20%	42%
Unresolved	Disorganized	1-2%		

TCU Institute of Child Development . (Producer). (n.d.). *Attachment Dance* [DVD]. Available from TCU.

Attachment Style: Child (Chara, 2005)

Characteristics	Secure	Avoidant-Insecure	Ambivalent Resistant Insecure	Disorganized Insecure
Reaction to caregivers' absence	Moderate Distress	Little Distress	Strong Distress	Confusion and Distress
Reaction to caregivers' presence	Seeks comfort and contact	Comfort and contact not strongly desired	Desires, but often rejects, comfort and contact	Desires, but wary of, comfort and contact
Caregiver's typical interactive style	Loving, involved, disciplining	Rejecting and unavailable	Inconsistent in meeting child's needs	Neglectful or abusive

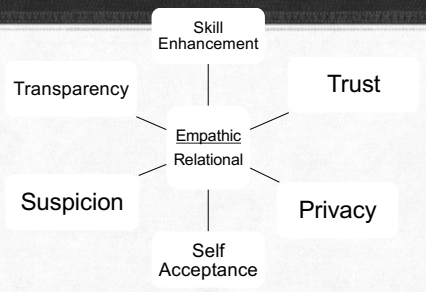
Child Dialectical Dilemmas



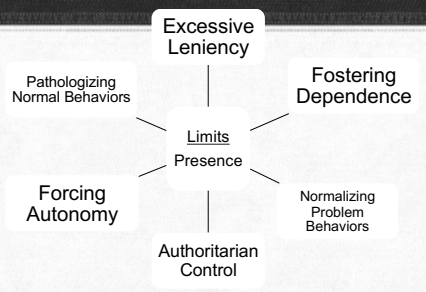
Attachment Style: Adolescent (Chara, 2005)

Characteristics	Secure	Avoidant-Insecure	Ambivalent Resistant Insecure	Disorganized Insecure
Predominant Emotions	Optimism; mature emotionality	Detachment; callousness	Anxiety, anger	Fear, doubt
Ability to Trust	Desires trust; finds it easy to trust	Indifferent toward trust mistrustful of others	Desires trust; but mistrustful of others	Desires, but wary of, trust, suspicious of others
Ability to be Intimate (mutual self-disclosure)	Desires intimacy; able to be intimate	Avoids intimacy; difficulty being genuinely intimate	Desires intimacy, but doubtful intimacy is sincere; difficulty being intimate	Intimacy desires mixed with fear and doubt; difficulty being intimate
Fear of Abandonment	Low; finds security in relationships	Low; indifference born of self-reliance	High; fears being rejected	High; strong fears of rejection

Adolescent Dialectical Dilemmas



Family Dilemmas



Parenting Styles

Authoritative

High nurturance, expectations, and control
Moderate communication

Authoritarian/Abusing

High expectations, and control
Low communication and nurturance

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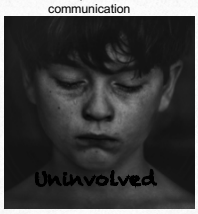
Parenting Styles

Neglecting

Low nurturance, expectations, control and communication



Permissive

High nurturance, moderate communication, low expectations, and control

Parentastic.org.

See You Next Week!

"There are no perfect relationships with no rips. We must become skilled masters of repair when the tears come."

Learning to Lean into the Storm

Strategies and Interventions for High-Risk Youth

Key Clinical Disorders

Week 2

Today's Objectives

1. Understand how to apply interventions to most prevalent child and adolescent disorders (e.g. ADHD/ADD, Oppositional Defiant/Conduct Disorder, Anxiety, Depression, Attachment Disorder, Eating Disorders, etc)
2. Utilize behavior modification strategies at the earliest stage of dysregulation.
3. Learn to focus on the function of the behavior versus the dysfunction of the behavior.

Statistical Prevalence of Childhood Disorders

Disorder	Prevalence	With Severe Impairment or Distress	Median Age of Onset
Anxiety	31.9%	8.3%	6 years of age
Behavior	19.1%	9.6%	11 years of age
Mood	14.3%	11.2%	13 years of age
Substance Use	11.4%	Not analyzed	15 years of age
Dual Diagnosis	40%	Not analyzed	Not analyzed

Merikangas, K.R., He, J-P, Burstein, M., Swanson, S.A., Avenevoli, S., Cui, L., et al. (2010). Lifetime Prevalence of Mental Disorders in U.S. Adolescents: Results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, 49,(10), 980-989. DOI: 10.1016 /j.jaac.2010.05.017

Statistical Prevalence of Childhood Disorders based upon multicultural factors

- Black Youth are significantly under-represented in mental health and treatment-oriented services and overrepresented in containment-focused facilities.[17]
- First Nations youth die by suicide about 5 to 6 times more often than non-Aboriginal youth.[18]
- LGBTQ youth face approximately 14 times the risk of suicide and substance abuse than heterosexual peers.[19]
- Youth living in the lowest-income neighborhoods had the highest rates of suicide, emergency department visits for deliberate self-harm, acute care mental health service use, treated prevalence of schizophrenia.[20]

[17] Gharabaghi, K., Trocmé, N. and Newman, D. (2016). Because Young People Matter: Report of the Residential Services Review Panel.
[18] Centre for Addiction and Mental Health. Mental Illness and Addictions: Facts and Statistics. Webpage: www.camh.ca/en/hospital/about_camh/newsroom/for_reporters/Pages/addictionsmentalhealthstatistics.aspx
[19] Canadian Mental Health Association - Ontario. Lesbian, Gay, Bisexual, Trans & Queer identified People and Mental Health. Webpage: www.ontario.cmha.ca/mental-health/lesbian-gay-bisexual-trans-people-and-mental-health/
[20] MHASEF Research Team. (2015) The Mental Health of Children and Youth in Ontario: A Baseline Scorecard. Institute for Clinical Evaluative Sciences.

Anxiety

- Anxiety is a natural response to threat (and the client expects threat)
- Validate the feelings and sensations as real *and* experientially challenge the notion that the feelings are intolerable
- Balance mindful acceptance of anxiety *with* relaxation and distress tolerance skills (e.g., breathing, muscle relaxation, positive self-talk, self-soothing skills)
- Increase predictability of schedules and any upcoming activities that threaten to dysregulate
- Frequently reorient to structure of therapy and place up visually on the wall of your group room
- Develop "Wild Cards" (Purvis, et al, 2007) with skills to manage changes

Attention-Deficit Hyperactivity Disorder

- Incorporate mindfulness and acceptance strategies daily
- Focus on Doing vs. Being mind
- Focus on nutritional management strategies-hydration, omega-3 fatty acids, targeted amino acid therapy (TAAT) (Purvis et al, 2007)
- Focus on incorporating self-monitoring strategies

Oppositional Defiant Conduct Disorder

- Multifamily therapy only
- Bring a family therapist on the team and open up multifamily skills training to all supporting family members
- Contingency management of all expectations (e.g. diary card, skills group homework)
- Keep child's world small and predictable with immediate consequences

Best Behavioral Methods to Create Change

- Make a high probability behavior contingent on a low probability behavior (i.e., Premack Principle)
- Reinforce anything and everything that is not a problem behavior (clients emit positive behaviors nearly continuously)
- Train a new behavior (skill) to reinforce
- Put a problem behavior on "cue" (i.e., bring it under stimulus control)
- Understand the motivation for the behavior and use it to leverage change

Behavioral Principles

You must become a behavioral specialist

Positive Reinforcement: behavior is followed by a reward, increasing the behavior's frequency
Negative Reinforcement (think avoidance learning): behavior is followed by removal of something aversive, increasing the behavior's frequency
Positive Punishment: behavior is followed by something aversive, decreasing the behaviors' frequency
Negative Punishment (think response cost): behavior is followed by removal of something, decreasing the behavior's frequency
Extinction: removal of any consequence for a behavior, leading to a decline in the behavior

Behavioral Principles

You must become a behavioral specialist

Shaping: reinforcing approximations to a desired behavior
Avoidance Learning: behavior results in the cessation of an aversive stimulus (falls under negative reinforcement)
Non-contingent Reinforcement: providing reinforcement regardless of behavior you want to decrease (but in absence of that behavior). The b then decreases as it is no longer necessary to receive the reinforcement
Generalization: performing desired behavior outside of treatment setting

Behavioral Contingencies

- The consequences of behavior influence what we learn
- A temporally **close** relationship between behavior and consequence influences what will happen the next time we are in a similar situation with similar context
- Highlighting contingencies (e.g., structure, expectations, safety, immediate feedback, etc.) helps clients learn and be more effective

Behavioral Principles: What to Consider

- Are effective behaviors reinforced? On what schedule? Be careful to *maintain* desired behaviors!
- How are ineffective behaviors reinforced (maintained)?
- How can I shape effective behaviors while extinguishing ineffective behaviors?
- Consider relevant behavioral principals when analyzing

Behavioral Change

Keys to the Kingdom:

Aim For Behaviors That Push But Do Not Exceed Client's Capabilities

Attachment Disorders

- Stability first! Client must have skills to tolerate distress (e.g., work on grounding skills, distress tolerance, and emotion regulation
- Incorporate emotion regulation strategies that prevent avoidance or escape behaviors (e.g. aggressive connection or dissociated drifting to strangers)
- Develop healthy connective strategies
- Teach healthy boundaries for child and parent

PTSD and Trauma

- Stability first! Client must have skills to tolerate distress (e.g., work on grounding skills, distress tolerance, and emotion regulation
- Linehan promotes exposure techniques
- Consider other ways to handle trauma (e.g., mindfulness and present-centered approaches)
- Incorporate Connected Child (Purvis, et.al, 2007)

Eating Disorders

- Often center on issues of identity and acceptability. Intense emotions result from self-loathing (food the focus of attention). Dialectics focus on urge indulgence vs. inhibition, helplessness vs. self-control, and acceptability of the individual to self and society.
- Validate experience-increase radical genuineness
- And develop positive identity and healthy controls (externalize disorder)

Eating Disorders

- Increase distress tolerance
- Increase emotion regulation
- Increase sensory input through mindfulness (again externalizing)
- Mindful eating followed by distraction or urge surfing helpful

Mindfulness/Acceptance Interventions

- Apply Core Mindfulness Skills
- Have client "sit with" emotion longer than he/she desires (i.e., exposure or desensitization)
- Have client change relationship to emotions and thoughts (not right/wrong or good/bad, but a different awareness based on acceptance and meaning making)

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Depression

- Depression happens when desires are frustrated, making hope difficult and leading to greater passivity.
- Validate the mood, especially given lack of positive experiences (reduces secondary guilt and shame).
- Challenge the ineffective strategies used to deal with the mood.

Depression

- Increase positive behaviors (coaching, prompting, contracting, etc.)
- Decrease mindfulness of negative experiences
- Build in self-care and emotion regulation skills

Substance Abuse/Dependence

- Validate needs and challenge means of meeting those needs
- Increase mindfulness of urges and then shift to external focus
- Decrease environmental triggers
- Increase distress tolerance and emotion regulation to deal with withdrawal and urges

Starting Out: Commitment Strategies

- Evaluate pros and cons of therapy
- Play the devil's advocate
- Foot in the door techniques
- Door in the face techniques
- Connect to prior commitments
- Highlight the freedom to choose (especially in the absence of alternatives)
- Shape stronger commitment (as therapy progresses)
- Coach and cheerlead

Carl Rogers

"The curious paradox is that when I accept myself just as I am, then I can change."

See You Next Week!

"There are no perfect relationships with no rips. We must become skilled masters of repair when the tears come."

Learning to Lean into the Storm

Strategies and Interventions for High-Risk Youth

Compassionate Connectors

Week 3

Today's Objectives

1. Understand how to practice validation to disrupt dysregulated behaviors and communication.
2. Learn how to balance prosodic communication (e.g. tone, pitch, etc) with self-validation and compassion.
3. Learn how to communicate and facilitate choice while simultaneously celebrating capability through finding a synthesis.

What should I look for?

Symptoms to Interventions

What to Look For

Self-Invalidation	• Self-hate/criticism • Perfectionism
Emotional Vulnerability	• Anger, Bitterness Towards Others • Fragility, Vulnerability
Inhibited Experiencing	• Active avoidance • Passive avoidance, dissociation

How to Help

Self-Invalidation	• Modeling failure • Communicating validation
Emotional Vulnerability	• Model self-care • Create a safe home environment
Inhibited Experiencing	• Model Emotions • Display authentic reactions without exaggeration

What to Look For

Unrelenting Crises	• Uncontrollable Events • Crisis-Generating Behavior
Active Passivity	• Willfulness, Demandingness • Helplessness
Apparent Competence	• Disconnect between verbal and non-verbal behavior • Contextual Competence (mood/situational)

How to Help

Unrelenting Crises	• Control the Controllable in the Home/School Environment • Practice/Model Delayed Gratification
Active Passivity	• Cheerlead • Encourage problem-solving • Set Personal Limits
Apparent Competence	• Highlight effective behaviors observed • Lose the assumption of how the loved one "should" behave in all contexts based upon one.

Validation: The Keys to the Kingdom

- Validation is the non-judgmental acknowledgement of the client's experience
- Validation creates the conditions of acceptance that usually precede change
- As a rule, start with validating the client, and return to validation when the client is "stuck" (remembering that rules have exceptions)

Balance of Validation and Change

- Validation opens clients to change:
  - Lets clients know you understand the nature of their issues and pain
  - Exposure to painful emotions create a qualitative difference in relating to emotions (decreasing ineffective escape and avoidance behaviors)
  - Exposure to painful emotions can create motivation to invest in change

Validation as an Exposure Technique

- Regulates emotions by decreasing their intensity
- Provides gentle, informal exposure to emotions with a sense of self-efficacy
- Allows for a more complete expression of emotions, cueing a fuller adaptive response

Levels of Validation
(Linehan, 1997)

- Being acutely attentive (V1)
- Reflecting verbal communication (V2)
- Describing non-verbal communication (V3)
- Expressing how experience makes sense given history or biology (V4)
- Expressing how experience makes sense in the present moment and context (V5)
- Being in genuine, human contact (V6)

VALIDATION PRACTICE

"I went to the coffee shop with my sister and her friends. I was sad because I had just broken up with my boyfriend. I forced my sister to lie to our parents because I saw a guy I used to hook up with and wanted to have sex with him. Now my parents don't trust me. I lost my driving privileges, my cell phone and can't hang out with my friends. I thought I was over my ex but now I'm in so much trouble. I don't want to eat and if my parents would leave me alone, I would find a knife to cut myself."

Self-Validation Module

- Developed by: Dr. Alan E. Fruzetti

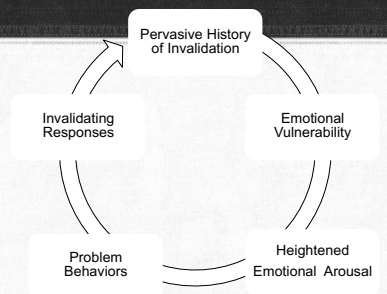
Goals

①Separating *experiences* (e.g., feelings, thoughts, desires, sensations) from things that cannot be observed in the present.

②Separating *aspects* of an experience that are valid from those that are not (or may not be) valid in the present moment.

③ Being effective

Cycle of Invalidation

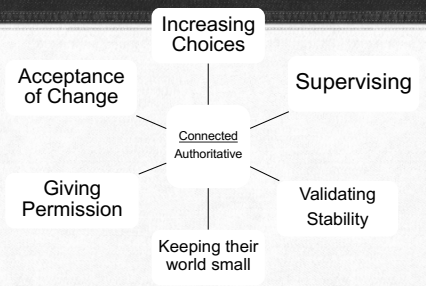


Self-Validating Statements

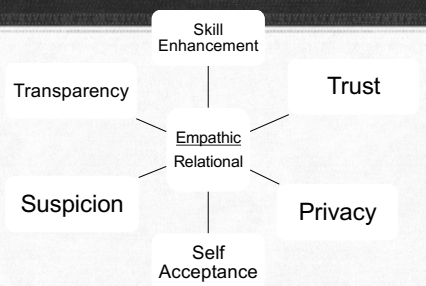
Prosodic Communication

- Intonation (pitch)
- Pitch contour.
- Pitch reset.
- Stress.
- Rhythm.
- Loudness.

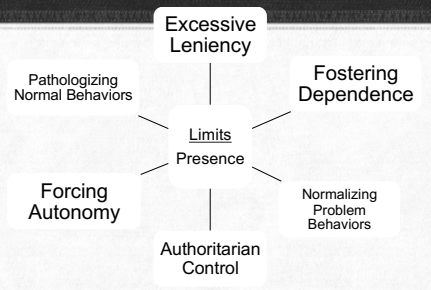
Child Dialectical Dilemmas



Adolescent Dialectical Dilemmas



Family Dilemmas



From Dysfunction to Function

- Non-judgmental, non-pejorative
- Look for the wisdom and truth in how the behavior was formed
- Explore how beliefs and dialectic conflicts formed
- Understand that clients are trying to meet needs
- Validate and teach them a more effective way

Practicing Non-judgment

No One Has Ever Observed…

- Others' Thoughts
- Others' Intentions
- Others' Emotions
  - Causes
  - Concepts
  - Meaning

Dialectical Skills Strategies

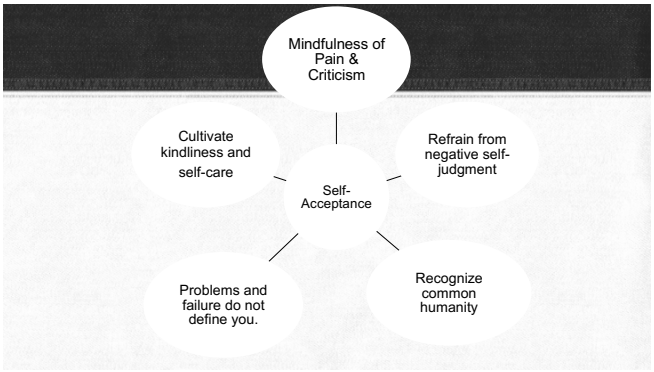
- Highlight the contradictions in client's behavior, approach to therapy or in reality
- Refusing "right and wrong;" different perspectives can both be true and answers can yes and no
- Avoid allowing the group or any leader to step in with logic to solve the dilemma or struggle; allow the client to make the shift (positive aspect of having two co-facilitators)

Other Dialectical Strategies

- Metaphor and Teaching Stories
- Playing Devil's Advocate
- Extending (aikido self-defense): Can be used with active resistance
- Activating Wise Mind
- Making Lemonade Out of Lemons
- Allowing Natural Change
- Dialectical Abstinence
- Dialectic Assessment: What's Missing?

Self-Compassion Module

- Goal-Decrease emotional suffering
- Developed by: Dr. Kristin Neff
- Module components:
  1. Self-Compassion Scale
  2. Using self-compassion skills to decrease emotional suffering
  3. Practicing self-soothing compassion
  4. Intrapersonal compassion skills (SACRED self)



Relational Agreements

1. Your loved one is doing the best he or she can.
2. Your loved one needs to do better, try harder, and be more motivated to change.
3. Your loved one wants to do things differently and make things better.
4. Your loved one must learn new behaviors in all important situations in his or her life.
5. Family members should take things in a well-meaning way and not assume the worst.
6. There is no absolute truth. [in relationships]

Adapted from *Parenting a Child Who Has Intense Emotions (Harvey and Penzo, 2009)*

Thank-you for your time!

"There are no perfect relationships with no rips. We must become skilled masters of repair when the tears come."